Fever

Patient Name	Inmate Number	Booking Number	Date of Birth	Today's Date

Check, circle, and complete all appropriate blanks.

Date: _____ Time: _____

S: Subjective:

Inquire about other symptoms. Include general systemic symptoms such as headache and malaise, and anything else the patient wishes to mention. _____

Inquire regarding recent activities. _____

Inquire regarding recent exposure to others who were sick. _____

Inquire regarding symptoms consistent with colds and URIs. _____

Inquire regarding new or recent onset abdominal problems. _____

Obtain a history of current medications, identifying those that have been started recently. _____

Inquire regarding recent use of aspirin or other NSAID, especially during the previous 24 hours. _____

O: Examination:

T: _____ P:_____ R:_____B/P:_____ WT:_____

Examine organ systems as suggested by clinical history and current symptoms._____

A: Assessment:

Assess as in the following table:

Temperature range (F)	Assess as:
Less than 99.6	No fever
Above 99.6 and below 101.9	Low grade fever
Above 101.9 and below 103.5	Significant fever
Above 103.5 and below 104.5	Dangerous fever
Above 104.5	Very dangerous fever

Assessment_____

P: Interventions:

For "no fever,"

- Instruct the patient to return if his condition worsens or other symptoms develop.

For "low grade fever,"

- Instruct patient that he has an elevated temperature but not to a significant degree.
- Schedule a follow up with nursing staff for a repeat fever evaluation the next day, and instruct patient to return if his condition worsens or other symptoms develop prior to scheduled reevaluation.
- Offer acetaminophen 975 mg PO unless contraindications exist. This may be repeated 1 time in 24 hours (BID) but the nurse is only authorized to provide a total of 2 doses without HCP consultation. If patient has documented allergy to acetaminophen, then provide ibuprofen 200mg PO TID x 1 day instead (unless otherwise contraindicated).
- Contact HCP if advice is needed.

For "significant fever"

- Administer EITHER acetaminophen 975 mg OR ibuprofen 200 mg (as allergies dictate) PO as a one time dose unless either has been given within a 6 hour period.
- Contact HCP for advice.

For "dangerous fever"

- Administer EITHER acetaminophen 975 mg OR ibuprofen 200 mg (as allergies dictate) PO as a one time dose unless either has been given within a 6 hour period.
- Contact HCP for advice.
- Prepare to cool the patient by application of cool wet sheets, application of ice bath, or other local methodology.

For "very dangerous fever"

- Administer EITHER acetaminophen 975 mg OR ibuprofen 200 mg (as allergies dictate) PO as a one time dose unless either has been given within a 6 hour period.
- Prepare cooling process and initiate cooling.
- Contact HCP for further direction.

Nurse's signature and date:

_____

Reviewer's signature and date:

_____

Foreign Body in the Eye

CCS CORRECT CARE SOLUTIONS

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

Check, circle, and complete all appropriate blanks.
If it has been noted that patient has been putting in numerous sick calls for similar complaints, refer patient for chart review with HCP to determine appropriate plan of care and follow-up.

Date:_____ Time:_____

S: Subjective:

Patient complains of something in his eye. _____

Inquire if the patient knows what is in the eye and how it got there. _____

Determine whether the discomfort developed "all of a sudden" or if it came on gradually over hours or days. _____

O: Examination:

T: _____
Visual acuity (if possible): Right- Left- Binocular-

Inspect the eye including under the eyelids. _____

If the irritation was caused by a chemical splash into the eye, go directly to the treatment section and flush the eye with eye wash, saline, or tap water. Then obtain the rest of the history.
If an object can be seen, watch the object when the patient blinks. If it moves, it is not embedded. If it does not move, it is at least adherent if not embedded. _____

If the object cannot be seen even when the lids are retracted to permit the entire conjunctiva to be seen, stain the eye with fluorescein and repeat the examination. _____

If the globe has been fully penetrated by a foreign object, proceed to treatment. _____

A: Assessment:
If nothing is seen even with staining, assess as "alteration in comfort (eye) – no cause identified."
If an object is identified as present and is not penetrating, assess as "alteration in comfort (eye) – foreign body on (conjuntiva or cornea)
If the eye has been penetrated, assess "alteration in eye integrity - penetrating eye injury."

Assessment _____

P: Interventions:
For chemical or irritating liquid in the eye
- Irrigate with copious amounts of saline, tap water, or eye irrigating solution for 15 minutes.
- Contact HCP for direction.

For "penetrating eye injury"
- Do not remove the object.
- Keep the patient quiet.
- Contact HCP for direction.
- Monitor vital signs.

For "alteration in comfort (eye) – no cause identified"
- Reassure patient that foreign object seems to have gone away.
- Advise patient to return if discomfort increases or eye turns red.

For "alteration in comfort (eye) – foreign body on (conjunctiva or cornea)"
- If a non-penetrating foreign body is identified, attempt to remove it by irrigating with copious amounts of saline, tap water, or eye irrigating solution. Reexamine periodically as this is being performed.
- If the object does not come away with irrigation, contact HCP for direction.
- If the pain continues unchanged despite the apparent successful removal of the foreign object, contact the HCP for direction.
- If there is any chance that a foreign object made of steel remains in the eye, contact the HCP for direction.

Comments: _____

Nurse's signature and date:

_____

Reviewer's signature and date:

_____

D2457DP61383PNXN

Head Injury

(This is a two page flow sheet)

CCS CORRECT CARE SOLUTIONS

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

Check, circle, and complete all appropriate blanks.

Date:_____ Time:_____

S: Subjective:

Manage the ABCs of trauma first – AIRWAY, BREATHING, AND CIRCULATION.
Determine how the injury occurred and what type(s) of forces were involved. _____

Inquire regarding even brief loss of consciousness. _____

If the patient is stable, inquire regarding other injuries. _____

Inquire regarding ringing in ears, dizziness, loss of coordination, vision problems, and loss of sensation (even temporary) _____

O: Examination:

P: _____ R: _____ BP: _____ Oxy Sat_____

Inspect the patient's eye opening responses, motor responses, and verbal responses. Complete the Glasgow Coma Scale (GCS) (separate form)
Inspect the patient's pupils for symmetry and reactions to light.

Inspect the scalp for injuries and palpate for a depressed fracture. _____

Inspect the skin for raccoon eyes (bruising around the eyes) or Battle's Sign (bruising behind the ears). Look for blood behind each ear drum.

A: Assessment:

Assess as "head injury – trivial" if all are present:
- the initial GCS score is greater or equal to 13
- there was no loss of consciousness
- no injury-specific physical exam abnormalities were noted, and
- the mechanism of injury did not involve large forces.

Assess as "head injury - mild" if
- the initial GCS is greater or equal to 13,
- confusion or focal neurological signs (if noted) resolves within 15 minutes, and
- loss of consciousness, if present, resolved within seconds.

Assess as "head injury – moderate" if **one** of the following is present (two or more pushes the assessment to severe)
- the initial GCS is between 9 and 12,
- focal neurological symptoms persist for more than 15 minutes,
- the patient experienced a seizure at the time of injury,
- the pupils are asymmetric,
- the patient develops delayed verbal or motor responses, becomes restless, has gross observable uncoordinated movements, or develops slurred or incoherent speech,
- vital signs change; respiration rate increased above 20 pm, pulse increased by 15 bpm over baseline, or systolic blood pressure goes up or down more than 15 mm, or
- Loss of consciousness lasted between a few and 30 seconds.

Assess as "head injury – severe" if **two or more findings under "moderate" are present** or **any** of the following are present
- initial GCS is below 9,
- patient's level of consciousness deteriorates,
- there are visible areas of deformities or a depressed area of the skull,
- there is a penetrating skull injury,
- clear or pink drainage is noted from a scalp wound, the nose, or the ear,
- ecchymosis is noted around the eyes or mastoid processes,
- pupils fail to react to light,
- the patient loses motor function or sensation, or
- respirations become irregular, pulse rate drops to below 60, or a widening blood pressure is noted.

Assessment _____

Head Injury

(This is a two page flow sheet)

CCS CORRECT CARE SOLUTIONS

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

P: Interventions:

Always address the ABCs, first and as necessary.
For "head injury – trivial"

- Perform serial observations including repeat GCS every 15 minutes for an hour and then every 30 minutes for another hour (2 hours observation in clinic or med unit).
- If the assessment does not change during these two hours, release the patient from the clinic or med unit and schedule a return visit to nursing on the next day.
- Instruct the patient to return sooner if new neurological symptoms present.

For "head injury – mild"

- House in med unit or other housing convenient to clinic. Perform serial observations (including GCS) every 15 minutes for one hour, every 30 minutes for one hour, every hour for the next four hours, and every four hours for the next 24 hours.
- For complaints of pain offer acetaminophen 975 mg PO BID while under supervision. If patient has documented allergy to acetaminophen, provide ibuprofen 200mg PO TID while under supervision unless otherwise contraindicated.
- If no additional abnormal findings develop during the observation period, the patient may return to the housing unit.
- Depending upon the circumstances, the nurse may restrict duties and activities for 24 or 48 hours.
- Instruct the patient to return if new neurological symptoms present.

For "head injury - moderate"

- Contact the HCP for immediate direction.
- Continue to perform observations serially, every 3 to 5 minutes until the HCP directs otherwise.
- Attend to ABCs as necessary.

For "head injury – severe"

- Activate EMS.
- Initiate oxygen therapy at 8-12 lpm.
- Initiate IV with 1000 cc NS and increase rate to maintain blood pressure above shock levels (90/60). Place second large bore IV if time/circumstances allow.
- Contact the HCP for immediate direction.
- Continue to perform observations serially, every 3 to 5 minutes until the HCP directs otherwise.
- Attend to ABCs as necessary.

If there is a foreign object penetrating the skull, do not remove it. Attempt to stabilize it so that no additional damage occurs.

Nurse's signature and date:

_____

Reviewer's signature and date:

_____

Glasgow Coma Scale and Flow Chart
(Head Injury)

CCS CORRECT CARE SOLUTIONS

Patient Name	*Patient Number*	*Booking Number*	*Date of Birth*	*Today's Date*

		time	Base-line							
Eye Opening Response	Spontaneous--open with blinking at baseline	4 points								
	Opens to verbal command, speech, or shout	3 points								
	Opens to pain, not applied to face	2 points								
	None	1 point								
Verbal Response	Oriented	5 points								
	Confused conversation, but able to answer questions	4 points								
	Inappropriate responses, words discernible	3 points								
	Incomprehensible speech	2 points								
	None	1 point								
Motor Response	Obeys commands for movement	6 points								
	Purposeful movement to painful stimulus	5 points								
	Withdraws from pain	4 points								
	Abnormal (spastic) flexion, decorticate posture	3 points								
	Extensor (rigid) response, decerebrate posture	2 points								
	None	1 point								
		Total								
		Nurse Initials								

Healthcare Professional Signature _____

D2459DP51394P

Headache

(This is a two page flow sheet)

CCS CORRECT CARE SOLUTIONS

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

Check, circle, and complete all appropriate blanks.
If it has been noted that patient has been putting in numerous sick calls for similar complaints, refer patient for chart review with HCP to determine appropriate plan of care and follow-up.

Date: _____ Time: _____

S: Subjective:

Inquire regarding the headache's onset. Was it sudden or gradual? What is the quality of the pain – severe, pounding, sharp, etc? Where does it hurt? _____

Inquire regarding the patient's general experience with headaches. Are headaches common or unusual? Any history of migraines? Is this headache like the patient's usual headaches? _____

Does the patient believe that this headache is worse than any other previously experienced? As the patient to rate the headache on a 1-10 scale with 10 being the worst. _____

Inquire regarding other medical conditions and current medications._____

Inquire regarding neurological symptoms, especially dizziness, loss of balance (including falls), disturbances in senses or in muscular control, sudden difficulty in ability to think, disturbances in vision, etc. _____

Inquire regarding neck pains or a stiff neck. _____

Inquire regarding nausea or vomiting. _____

O: Examination:

T: _____ P: _____ R: _____ BP: _____

Inspect the eyes for pupillary symmetry and pupillary responses. Do the eyes move normally together? _____

Inspect facial movements and note any asymmetry. _____

Listen to the patient's speech and identify abnormalities. _____

Have the patient lie down on a table with his legs extended. Can the patient touch his chin to his chest without bending and lifting his legs? _____

Watch the patient walk and observe the patient's movements for symmetry and coordination. _____

A: Assessment:

If the headache onset was sudden and the patient rates the headache a 10 (one of the worst headaches in the patient's life), assess "headache – rule out intracerebral event."

If the headache is subjectively severe (greater than 6), fever above 101 is present, and the patient cannot flex his neck (chin to chest) pain-free and without lifting and flexing his legs, assess "headache – rule our meningeal inflammation."

If objective findings are normal and the headache has no unusual characteristics (associated neurological symptoms, excessively high blood pressure, precipitating trauma, etc), assess "headache – nonspecific with normal findings."

If the headache is characterized by premonitory aura or a pounding nature, assess "headache – rule out migraine or cluster."

If the headache is accompanied by significant positive physical findings other than mild changes vital signs, the headache is a secondary phenomenon and the assessment should address the primary findings.

If the headache does not fit any of the above categories, assess "headache – uncertain type."

Assessment _____

Headache

(This is a two page flow sheet)

Patient Name	Inmate Number	Booking Number	Date of Birth	Today's Date

P: Interventions:

For "headache – rule out intracerebral event"
- Contact the HCP.
- Keep the patient under continuous observation while awaiting directions.
- Monitor vital signs, documenting every five minutes.
- If vital signs deteriorate, provide oxygen by mask at 8 lpm.

For "headache – rule out meningeal inflammation"
- Contact HCP for advice.

For "headache – nonspecific with normal findings"
- Advise patient that simple aspirin or acetaminophen may relieve pain, but that the headache does not require treatment.
- If the patient appears very uncomfortable, the nurse may provide a single dose of acetaminophen 975 mg PO.

For "headache – rule out migraine or cluster"
- Review chart for preexisting orders. (Migraine and cluster headaches will rarely present for the first time during confinement in a jail.)
- If there are preexisting orders, follow them.
- If this appears to be a first time presentation, contact the HCP for orders.

For "headache – uncertain type"
- Contact the HCP to discuss the patient.

If the headache is a secondary phenomenon, manage in accordance with the primary problem.

Comments: _____

Nurse's signature and date:

_____

Reviewer's signature and date:

_____

Human Bites

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

Check, circle, and complete all appropriate blanks.

Date:_____ Time: _____

S: Subjective:

Inquire regarding the mechanism of injury. _____
_____
_____
_____

Determine when the injury occurred. _____
_____
_____

If not known, try to identify the person whose mouth caused the injury._____
If the injury did not occur just prior to the examination, inquire regarding signs of infection (erythema, swelling, pain, and pus)
_____
_____
_____

O: Examination:

If the injury occurred just prior to the evaluation, vital signs are not necessary unless there is another reason for them.
If the injury is more than 12 hours old, obtain temperature, pulse, and blood pressure. T _____P _____ BP _____
Inspect the injury and the area surrounding the injury. _____
_____
_____
_____
_____

_Note especially in the case of closed-fist injuries whether there is skin break above a tendon sheath or above a knuckle. Assess range of motion in affected extremity. _____
_____
_____

Gently percuss or palpate the areas adjacent to the injury, noting pain or disruption of underlying structures. _____
_____
_____
_____

A: Assessment:

If there is no break in the skin, assess based upon other injuries; there is no human bite wound.

If there is a break in the skin that appears to have been caused by teeth or dentures, assess as "Human Bite Wound."

If there are signs of infection, assess as "human bite wound, infected."

If there are additional related problems such as a fracture or a skin opening extending into a tendon sheath, alteration in range of motion etc. assess as "human bite wound – complicated."
Assessment _____

P: Interventions:

If there is no bite wound, manage any other injuries or conditions.

For **all** human bite wounds
- If there has been no tetanus vaccination within the past 5 years, provide Td 0.5 ml IM in the deltoid muscle unless there is a contraindication.

For uncomplicated human bite wounds:
- Clean the area with soap and warm water.
- Cover with a clean dry dressing.
- If the wounds are uncomplicated but there are a large number of them, in addition to cleaning and dressing the wounds as above, contact the HCP for additional advice.

For complicated human bite wounds
- After cleaning with soap and warm water, contact the HCP for direction.

For infected human bite wounds
- Contact the HCP for direction.

Comments: _____
_____
_____
_____
_____
_____
_____
_____

Nurse's signature and date:

_____

Reviewer's signature and date:

_____

Hypertension

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

Check, circle, and complete all appropriate blanks.

Date:_____ Time:_____

S: Subjective:

Patient presents with history of hypertension (booking area), with sporadic reading above 140/90 (clinic visit) (130/80 for persons at special risk), or with repeated reading above 180/110 at any time.
For patients who report a history of hypertension, inquire when the diagnosis was made and what interventions have been attempted to obtain blood pressure control. _____
_____
_____
Obtain a history of medication prescriptions and medication adherence. Inquire into use of illicit drugs._____
_____
_____
_____
Inquire regarding major target organ damage – heart trouble, stroke, kidney damage. _____
_____
_____
_____
Inquire regarding major co-factors making patient high risk for target organ damage – diabetes, smoking, kidney damage, history of stroke or heart attack, or established coronary artery disease. _____
_____
_____
_____
_____

O: Examination:

P:_____ R:_____B/P:_____ Wt:_____
If blood pressure is elevated, obtain a repeat in standardized conditions.

Standardized conditions for blood pressure include 30 minutes of rest without caffeine or nicotine, with the patient seated or semi-recumbent with the upper arm supported at about the level of the heart, with the reading obtained twice two minutes apart. Depending upon the circumstances, it may also include pressures obtained supine, sitting, and standing.

Blood pressure readings: _____
_____
_____
_____

A: Assessment:

If the blood pressure is above 180/110, assess "hypertension out of control."
If the blood pressure is below 90/60, assess "hypotension."
If the patient in booking gives a history of hypertension currently on medication and pressures are normal to as high as 180/110, assess as "hypertension on treatment."
If the blood pressure is above 140/90 (130/80 high risk patients) but below 180/110, assess "possible hypertension."

Assessment _____

P: Interventions:

In booking:

- If "hypertension out of control" or "hypotension" contact HCP for direction.
- If "hypertension on treatment" or "possible hypertension," schedule for routine physical examination.
- If a medication history was obtained, attempt to verify the prescription(s) with the pharmacy or the prescriber's office.
- Contact HCP during business hours for directions regarding medications and follow up.
- Schedule for blood pressure checks twice weekly during the following two weeks and provide results to HCP for planning use.

In clinic setting (in population):

- If "hypertension out of control" or "hypotension" contact HCP for direction.
- If "hypertension on treatment" and pressure is normal, reassure patient and inform patient that chronic care clinic visit is scheduled.
- If "possible hypertension," schedule for twice weekly blood pressure checks during the following two weeks and provide results to HCP for planning use.

Comments: _____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Nurse's signature and date:

_____

Reviewer's signature and date:

_____

Hypoglycemia

Patient Name	Inmate Number	Booking Number	Date of Birth	Today's Date

Check, circle, and complete all appropriate blanks.
If it has been noted that patient has been putting in numerous sick calls for similar complaints, refer patient for chart review with HCP to determine appropriate plan of care and follow-up.

Date: _____ Time: _____

S: Subjective:

Patient presents complaining that his sugar is low.
Ask the patient to describe his symptoms. _____
_____
_____

Ask the patient what he has already done to manage the symptoms. _____
_____
_____
_____
_____

Obtain a fingerstick blood sugar and then inquire regarding the day's food intake, medication usage, and activities. _____
_____
_____
_____
_____

Diabetes patient presents with coma, seizure, or with other severe brain dysfunction.
No subjective information is available, but patient is identified as diabetic and on medication.

O: Examination:

P:_____ R:_____B/P:_____
Obtain fingerstick sugar. _____
If sugar is not low and patient does not have severe brain dysfunction, observe patient for 10 minutes and then repeat.
_____
_____
_____

If patient has severe brain dysfunction, describe_____
_____
_____
_____
_____

A: Assessment:

If signs and symptoms are consistent with mild or moderate hypoglycemia and blood sugar is below 50 or falling rapidly, assess as "alteration in blood sugar – hypoglycemia" and note mild or moderate.

If major brain dysfunction is present and blood sugar suggests severe hypoglycemia, assess as "alteration in blood sugar – severe hypoglycemia" and note the major dysfunction.
Assessment _____

P: Interventions:

For "alteration in blood sugar – hypoglycemia" (mild or moderate)

- Provide 15-25 grams of carbohydrate orally (preferably liquid and not a mixture with protein or fat). Examples of choices include 1-2 TBS maple syrup, 6 oz of orange juice, or 25 grams of hard sugar candy.
- If the hypoglycemia resulted because of a missed or inadequate meal, or because of unaccustomed physical activity the patient will need additional food. In this circumstance, it is better to permit the patient to eat too much than to permit the hypoglycemia to recur.
- Repeat fingerstick every 10 minutes as necessary until blood sugar is stable at an acceptable level. (Contact HCP if achieving this is problematic.)
- If this is an isolated episode of hypoglycemia (for example, the first episode in 30 days), no HCP follow up is necessary.
- If this is a recurrent near daily event, contact the HCP for direction.
- If the frequency is in between common and rare, schedule a chart review for the HCP on the next clinic day.

For "alteration in blood sugar – severe hypoglycemia"

- Administer 50 ml of 50% Dextrose IV or 1 mg glucagon by any parenteral (non-oral) route. Recheck fingerstick glucose after 5 minutes.
- If possible, initiate IV line with 5% Dextrose solution and infuse at KVO rate.
- Respond to other major problems as necessary.
- Contact HCP for direction.
- If patient does not respond within 10 minutes with improvement and HCP has not responded, activate the EMS by calling 911.

Comments: _____
_____
_____
_____
_____
_____
_____

Nurse's signature and date:

_____

Reviewer's signature and date:

_____

Insect Bites

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

Check, circle, and complete all appropriate blanks.
If it has been noted that patient has been putting in numerous sick calls for similar complaints, refer patient for chart review with HCP to determine appropriate plan of care and follow-up.

Date:_____ Time:_____

S: Subjective:

Patient complains of an insect or spider bite. _____
_____
Identify any difficulty breathing or suggestion that a systemic reaction is occurring. _____
_____
Determine when the bite/sting occurred, type of insect if known, nature of local reaction. _____
_____
_____
Inquire regarding any previous systemic reactions, recording details._____
_____
Identify current medications and serious medical diagnoses.
_____
_____

O: Examination:

T: _____ P:_____ R:_____B/P:_____
Note:
If respiratory distress is present or any respiratory abnormality is identified, rule out anaphylaxis before proceeding)
If pulse or blood pressure is abnormal, obtain oxygen saturation._____
Inspect the lesion(s). Note especially the presence of retained insect parts and any signs suggesting local infection. _____
_____
_____
If there are signs of local infection (erythema, pus, heat, swelling), inspect for ascending infection and palpate for swollen lymph nodes in that area. _____
_____
_____
If there are signs of local infection, inspect the lower legs to identify the presence of multiple small abscesses suggestive of CA-MRSA. _____
_____
_____
Inspect the face and torso if there is any suggestion of systemic complications, identifying hives, erythema, or edema.
_____
_____
_____
If dyspnea is present, inspect and listen to the chest and upper airway. _____
_____
_____
_____

A: Assessment:

- Assess as "anaphylaxis," "insect bite," "alteration in skin integrity – infection," or "no problem."
- If patient identifies "multiple spider bites" and has multiple infections, assess "alteration in skin integrity – possible CA-MRSA."

Assessment _____

P: Interventions:

For "anaphylaxis"
- Exit this pathway and use the anaphylaxis pathway.

For "insect bite"
- Remove any retained insect parts by gentle scraping, taking care not to squeeze any retained venom sac.
- Reassure the patient that the itching or pain will go away and encourage the patient not to scratch.
- Advise the patient that application of cool compresses or ice (as available) will temporarily relieve itching, but that no medication is necessary.

For "alteration in skin integrity – infection"
Take one of the following actions.

- If the infection is limited to a single lesion less than 0.5 cm, advise the patient to apply warm compresses for 15 minutes three or four times a day. Advise the patient to return if the lesion is not better in two days.
- If the infection is characterized by multiple lesions without drainage or signs of ascending infection, obtain a temperature.
  - If the temperature is less than 100 F, schedule the patient to be see HCP per routine
  - If the temperature is greater than 100 F, contact the HCP for advice.
- If the infection is characterized by multiple lesions with drainage or accompanied by signs of ascending infection, contact the HCP for advice.

For "alteration in skin integrity – possible CA-MRSA"
- If afebrile, refer to HCP per routine.
- If temperature is over 100, contact HCP for direction.

Comments: _____
_____
_____
_____

Nurse's signature and date:

_____

Reviewer's signature and date:

_____

Menstrual Difficulties

Patient Name	Inmate Number	Booking Number	Date of Birth	Today's Date

Check, circle, and complete all appropriate blanks.
If it has been noted that patient has been putting in numerous sick calls for similar complaints, refer patient for chart review with HCP to determine appropriate plan of care and follow-up.

Date: _____ Time: _____

S: Subjective:

Depending upon the presenting symptoms, different questions may be asked.
Obtain a menstrual history, including length of cycle, length of menses, regularity of cycle, history of sexually transmitted diseases, when current bleeding began, and typical associated symptoms. Inquire about use of oral contraceptive pills and Depo-Provera including length of use and last dose._____

Inquire regarding bleeding between periods. _____

Determine when last pregnancy took place (if any). _____

If excessive bleeding is an issue, inquire how rapidly napkins/tampons are becoming **saturated** (# per hour) and request the patient to hold onto the next pad. _____

Inquire regarding whether the current symptoms are different from her usual symptoms, and if so, how. _____

Inquire regarding other serious illnesses, or medications being used. _____

Inquire regarding how she usually manages her menstrual difficulties. _____

O: Examination:

T: _____ P: _____ BP: _____
Inspect the pads and estimate how saturated they are._____

Palpate the abdomen to search for rebound tenderness_____

A: Assessment:

- If findings are abnormal (temperature is elevated above 100.9 F, rebound tenderness is present, or pulse and blood pressure suggest blood loss), assess as "excessive menstrual flow with abnormal physical exam".
- If findings are normal and menstrual bleeding is confirmed, assess as "alteration in comfort, menstrual discomfort."
- If findings are normal but bleeding is excessive, also assess as "alteration in comfort, excessive menstrual flow."

Assessment _____

P: Interventions:

For assessment of "excessive menstrual flow with abnormal physical exam"
- Contact HCP immediately for advice.

For assessment of "alteration in comfort, menstrual discomfort"
- Advise patient to follow usual self-care if possible.
- If patient is so uncomfortable that simple analgesia is indicated, provide acetaminophen 975 mg PO BID for three days. If patient has documented allergy to acetaminophen, provide ibuprofen 200mg PO TID x 3 days (unless otherwise contraindicated).

For "alteration in comfort, excessive menstrual flow"
- Contact HCP for advice.
- Advise patient to return if period continues for more than 7 days, blood flow becomes excessive (saturating more than three napkins within 6 hours), bleeding develops between periods, or fever develops.

Comments: _____

Nurse's signature and date:

Reviewer's signature and date:

Muscular Aches

(This is a two page flow sheet)

CCS CORRECT CARE SOLUTIONS

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

Check, circle, and complete all appropriate blanks.
If it has been noted that patient has been putting in numerous sick calls for similar complaints, refer patient for chart review with HCP to determine appropriate plan of care and follow-up.

Date: _____ Time: _____

S: Subjective:

Obtain a detailed description (cause if known, recent activities, onset, frequency, duration, location, radiation, past injuries, exacerbating and relieving factors, etc.) _____

Inquire specifically about participation in muscle strength contests, excessive exercising ("Tyson squats"), etc. _____

Inquire regarding weakness, abnormal pains or sensations, or numbness. _____

Inquire about other medical diagnoses and current medications. _____

O: Examination:

P: _____ R: _____ BP: _____
Expose and inspect the affected body part(s). _____

Gently palpate the affected body parts. If a joint is involved and is not deformed, gently move it through its range of motion noting crepitus, patient reaction, etc. Do not force it if the patient indicates it is very painful. _____

Note any bruising. _____

Inspect involved joints for swelling and erythema. _____

Palpate involved joints for heat. _____

A: Assessment:

If there are no findings other than the patient's complaints of pain and minimal swelling in the area (without bony deformity), assess "alteration in comfort - nonspecific."
If there are findings suggestive of a serious injury (for example, severe pain upon motion of a joint, bony deformity, a reddened swollen joint, severe point tenderness especially over a bony prominence, positive neurological findings), assess "alteration in comfort - significant but nonspecific."
If the patient does not have a serious injury but there is a complicating concern such as anticoagulation, assess "alteration in comfort of unknown significance."
If the patient participated in a muscle strength contest, excessive exercising, etc. assess as "alteration in comfort – rule out myoglobinuria."

Assessment _____

P: Interventions:

For "alteration in comfort, nonspecific, take the following steps (modifying as appropriate for the part of the body involved):
For muscle pain from unaccustomed activity or exertion,

- Advise rest for a few days; provide directions to custody as necessary. This is generally all that is necessary, but if discomfort is severe, provide acetaminophen 975 mg PO BID x 2 days. If patient has documented allergy to acetaminophen, provide ibuprofen 200mg PO TID x 2 days instead (unless otherwise contraindicated). Advise the patient to refrain from additional physical activity until better and to return for reevaluation if the problem does not resolve over the following two days or worsens.
- If the injury was accompanied by a twisted joint or a joint that was flexed into an abnormal position, apply the RICE sequence providing ACE wrap for affected joint as necessary. Provide analgesic medication if indicated as outlined above. Advise the patient to refrain from additional physical activity until better and to return for reevaluation if the problem does not resolve over the following two days, worsens significantly, or if significant swelling develops.
- If bruising is present, apply the RICE sequence providing ACE wrap for affected area as necessary. Provide analgesic medication if indicated as outlined above. Advise the patient to refrain from additional physical activity until better and to return for reevaluation if the problem does not resolve over the following two days or worsens, or if significant swelling develops.
- If necessary, activity restrictions and assistive devices (cane, crutches) or a bottom bunk may be provided on a temporary basis (a few days) - provide directions to custody as necessary.
- For minor muscle and joint problems, no follow up is necessary unless the problem persists. However, if assistive devices are provided, a follow up evaluation should be scheduled in one or two days.

Muscular Aches

(This is a two page flow sheet)

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

For "alteration in comfort – significant but nonspecific" or "alteration in comfort of unknown significance"

- Place the patient at rest and contact the HCP for direction.

For "alteration in comfort – rule out myoglobinuria"

- Obtain dipstick urinalysis
- If urine is positive for protein and discolored brown or red, contact HCP for direction.
- If urine does not suggest the presence of myoglobin, manage as suggested in other options.

Comments: _____

_____

_____

_____

_____

_____

_____

Nurse's signature and date:

_____

Reviewer's signature and date:

_____

Nausea and Vomiting

Patient Name	Inmate Number	Booking Number	Date of Birth	Today's Date

Check, circle, and complete all appropriate blanks.
Date:_____ Time:_____

S: Subjective:

Distinguish between nausea and vomiting. _____
_____

If vomiting has occurred, determine when it started and what triggered it, how many times it has occurred, what has been vomited, and whether this episode is unusual. _____
_____
_____

Inquire specifically whether there has been hematemesis (blood in vomitus) or coffee ground material; and if so, how much. _____
_____

Inquire regarding recent head injuries. _____
_____

Record the occurrence of headache, blurred vision, disturbed consciousness, dizziness or lightheadedness, syncope, stiff neck, combination of recent increased thirst and urination, or diarrhea.
_____
_____

Inquire regarding abdominal pain and, if it is present, define it as to onset, severity, character, location, what makes it worse, and what makes it better. _____
_____
_____

If the patient is female, inquire regarding pregnancy and menses. ___
_____

O: Examination:

T: _____ P:_____ R:_____ B/P:_____ Wt:____
Check for orthostatic changes in pulse or blood pressure _____
_____
_____

Identify the patient's general status, identifying injuries or other obvious abnormalities. _____
_____
_____

Inspect the patient's abdomen, listen for bowel sounds (two full minutes of silence before concluding that there are none), and palpate for rebound tenderness. _____
_____

Perform a screening neurological examination and flex the neck gently to look for meningeal signs. _____
_____

A: Assessment:

Nausea and vomiting are symptoms caused by something else. The assessment should reflect the nurse's findings and, if the nurse is uncertain, the advice provided by the HCP.

Assessment _____

P: Interventions:

If any of the following are present, contact a HCP immediately to request advice:

- Changes suggestive of orthostatic hypotension (drop of diastolic greater than 10 mm, systolic greater than 20 mm, increased pulse of greater than 10 bpm,)
- Temperature above 100 F.
- Severe headache, especially of sudden onset.
- Identification of <u>new</u> neurological findings suggestive of cerebrovascular event (stroke, intracranial bleed, etc).
- Stiff neck or other suggestion of meningeal signs.
- Severe abdominal pain persisting even when not vomiting.
- Complete absence of bowel sounds or the presence of rebound tenderness.
- Persistence of vomiting for more than 2 days (one day if episodes are nearly uninterrupted).
- Head trauma.
- Severe trauma to the abdomen or chest.
- Symptoms suggestive of a myocardial infarction (heart attack).
- Bleeding, whether of bright red blood or coffee ground material.
- Drug or alcohol toxicity.
- Pregnancy with uncontrollable vomiting.
- Patient's vomiting is self-induced.
- The patient has previously been evaluated through this pathway for this problem within 36 hours.

If <u>none</u> of the above is present or applies, the patient can be provided with symptomatic relief:

- Clear liquid diet for 24-36 hours.
- Bed rest or other activity restriction if vomiting is intractable; provide directions to custody as necessary.
- Advise the patient not to try solid foods for at least 4 hours after the last episode of vomiting.
- Permit ice chips or sips of water ad lib.
- After 24 hours without vomiting, permit introduction of small quantities of solid foods.
- Instruct the patient to return if
  - Vomiting becomes violent or continuous.
  - Blood is seen in the vomitus.
  - Pain localizes in the abdomen to one spot.
  - Vomiting returns with the introduction of small quantities of solid foods.
  - Pateint develops stiff neck or fever.

Nurse's signature and date:

_____

Reviewer's signature and date:

_____

Nose Bleeds

Patient Name	Inmate Number	Booking Number	Date of Birth	Today's Date

Check, circle, and complete all appropriate blanks.

Date:_____ Time:_____

S: Subjective:

Determine quickly if there was an obvious cause. Patients will admit to being struck (typically "walked into a door") but will not admit to nose-picking. If the patient experienced major trauma (for example, clubbed on the face), this pathway should be exited the head injury pathway should be followed. _____

Inquire regarding the duration of the bleeding and what the patient has already attempted. _____

Inquire regarding other serious medical conditions (i.e. bleeding disorders) and medications (especially aspirin or coumadin). _____

O: Examination:

P:_____ R:_____B/P:_____

If there was a history of minor trauma to the face, inspect the face and skull, including the eyes and extra ocular movements, and palpate the face around the nose to search for obvious fractures.

Have the patient sit straight up and determine whether blood flows from the front of the nose or down the back of the throat. Note the quantity of blood involved. _____

A: Assessment:

If blood is not flowing/dripping from the nostril(s) or down the throat assess "nosebleed – minor or resolved."
If blood is flowing/dripping from the nostril(s) assess "nosebleed - anterior."
If blood is flowing down the throat assess "nosebleed – posterior."
If vital signs are suggestive of a different problem, assess (and intervene) accordingly

Assessment_____

P: Interventions:

For "nosebleed – minor or resolved"

- Provide education regarding avoidance and management of nosebleeds.

For "nosebleed - anterior" or "nosebleed – posterior"

- Place the patient in a seated upright position (unless other injuries make this impossible, in which case the patient may be placed in a semi-recumbent position.)
- Provide the patient with gauze sponges and instruct him to pinch both nostrils together, gently, but firmly enough to prevent blood from exiting the nose, and to hold the nostrils together for a timed, uninterrupted 15 minutes. (For posterior bleeds it may not be necessary to apply any pressure on the nostrils.)
- If bleeding continues after this but is decreased in volume, repeat once. If bleeding has stopped, provide education regarding avoidance and management of nosebleeds.
- If bleeding does not stop after two, uninterrupted 15 minute periods as above, reassess vital signs and contact HCP for direction.

Comments: _____

Nurse's signature and date:

Reviewer's signature and date:

Penile Discharge

Patient Name	Inmate Number	Booking Number	Date of Birth	Today's Date

Check, circle, and complete all appropriate blanks.
If it has been noted that patient has been putting in numerous sick calls for similar complaints, refer patient for chart review with HCP to determine appropriate plan of care and follow-up.

Date: _____ Time: _____

S: Subjective:

Patient complains of a discharge from the penis and/or of burning when initiating urine stream. (If only one is described, inquire about the other's presence.)
Inquire regarding quantity of discharge, when it is present, when it started, what color it is, and whether it is present throughout the day. _____

Inquire whether the burning is present for more than just initiation of the stream, and whether it is present throughout the day or only with the first urination of the day. _____

Inquire regarding known sexual exposure to an infected person.

Inquire whether any joints hurt. _____

Inquire whether the patient has identified any new rashes since the discharge was noted. _____

O: Examination:

T: _____
Inspect the penis and identify blisters, inflammation, discharge, etc. **(Chaperone (same or opposite sex) must be present.)** _

Inspect and describe any joints or rashes identified by the patient.

A: Assessment:

Assess as "alteration in comfort – urethritis."
If blisters are present, assess as "alteration in comfort – urethritis, possible herpes infection."
If blood is present (discharge is red or pink) assess as "alteration in comfort – bloody urethritis."
If a joint is noted to be swollen, red, and hot, assess also as "alteration in comfort – joint inflammation."
If a new rash is noted and patient has a fever, assess also as "alteration in skin integrity - possible sepsis."
Assessment _____

P: Interventions:

Note: For each category of urethritis, a DNA probe or urine test for gonorrhea and chlamydia should be obtained.
For "alteration in comfort – urethritis, possible herpes infection"

- Obtain additional history regarding previous episodes and frequency.
- If patient is immunosuppressed, schedule to see HCP per routine.
- If patient is not immunosuppressed, schedule HCP to review health record and determine whether additional evaluation or intervention is necessary.

For "alteration in comfort – bloody urethritis"

- Obtain additional history inquiring specifically regarding instrumentation of the penis and possible relationship between masturbation and bleeding.
- If history suggests that bleeding may be related to trauma, instruct patient to cease traumatizing the penis and schedule him back in one week for a nursing assessment. If this trauma seems to indicate self-injurious intent or other serious mental health issues, contact mental health provider on-call.
- If history does not include possible trauma to the penis or patient has returned with continuing bleeding, schedule to HCP; if next day follow-up deemed necessary, contact HCP on-call prior to scheduling.

For "alteration in comfort – joint inflammation" or "alteration in skin integrity – possible sepsis"

- Contact HCP for direction.

Comments: _____

Nurse's signature and date:

Reviewer's signature and date:

Pepper Spray Exposure

CCS CORRECT CARE SOLUTIONS

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

Check, circle, and complete all appropriate blanks.

Date: _____ Time: _____

S: Subjective:
Patient presents after being exposed to pepper spray.
Inquire regarding the nature of exposure; what did the spray hit? (mouth, nose, eyes, skin?)

When was the exposure?

What symptoms does the patient report?

In patients over age 50 or with history of CAD, inquire specifically for chest pain suggestive of a stress-related cardiac event. If present, describe.

Does the patient have a serious chronic pulmonary or cardiac disease?

O: Examination:
Wear gloves.
P:_____ R:_____B/P:_____ OxySat_____
Examine the lungs for bronchospasm (wheezes).

If the eyes are open, examine briefly for mechanical perforation. Describe appearance and findings:

A: Assessment:
Assess as "OC exposure" and specify what parts of the body were exposed:_____
_____
Assess related secondary concerns if present:
cardiac event?_____
pulmonary embarrassment_____
eye globe perforation:_____
other: _____

P: Interventions:

If eye globe is perforated
- Patch lightly with gauze
- Arrange to send to hospital by car

If acute MI is suspected:
- Follow pathway for suspected acute MI, including but not limited to aspirin, oxygen, and ambulance

If acute asthma exacerbation is present:
- Provide albuterol by nebulizer as described in asthma protocol.
- If the patient does not improve after initial nebulization treatment, arrange to send to hospital by car (by ambulance if the exacerbation is severe or oxygen saturation is below 92).

For eye exposure (without globe perforation):
- Irrigate with copious flow of water for 15 minutes or more, from the nasal to the temporal.
- Remove contact lenses if present (patient may need to assist). Return them to the inmate but advise that they not be worn.
- If blistering or perforation is noted, contact HCP for direction.
- Reassure patient that erythema and pain will disappear (erythema within a day, pain within an hour or two).
- Keep patient under observation until eye pain is relieved; contact HCP if this does not occur within 2 hours.
- Bring patient back approximately 24 hours after exposure for eye check.

For skin exposure:
- Remove clothing (must be washed or thrown away).
- Irrigate with flowing water for 15 minutes or more.
- Call HCP if blistering is present.

For respiratory exposure:
- Unless asthma exacerbation is present (see above), reassure patient.
- Observe patient at least every 15 minutes until respiratory symptoms are gone.
- If observation is required for more than 2 hours, contact HCP for direction.

For nasal exposure:
- If possible, treat as for respiratory exposure. (Irrigation is typically impossible).

Comments: _____
_____
_____
_____
_____
_____
_____

Nurse's signature and date:

_____

Reviewer's signature and date:

_____

Pink Eye

(This is a two page flow sheet)

CCS CORRECT CARE SOLUTIONS

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

Check, circle, and complete all appropriate blanks.
If it has been noted that patient has been putting in numerous sick calls for similar complaints, refer patient for chart review with HCP to determine appropriate plan of care and follow-up.

Date: _____ Time: _____

S: Subjective:

Inquire regarding the onset and duration of symptoms _____

Inquire regarding vision changes _____

Inquire regarding trauma, exposure to chemicals, splashed liquids, powders, or other foreign bodies. _____

Inquire regarding previous episodes and, if they occurred, what treatment (if any) was received _____

Inquire regarding other serious medical conditions that may be present _____

Inquire regarding the patient's allergy history _____

Has the patient recently changed cosmetics, especially eye makeup? _____

O: Examination:

T: _____
Perform a Snellen examination _____

With examination gloves, examine both eyes. Are any foreign bodies noted? _____

Note the pupils' responses to light and accommodation. Are the pupils round? _____

Note the pattern of redness. Is it diffuse, or greater at the edge of the pupil, or adjacent to the whites of the eyes? _____

Is there any obvious crusting or a small abscess associated with an eyelash? _____

Is there associated swelling, either around an eye or in front of an ear? _____

Assess extraoccular movements noting any abnormalities or complaint of pain with eye movement. _____

Is there a rash on the face especially around the involved eye?

If fluorescein dye strips are available and the nurse has been trained to use them, examine the conjunctivae and corneas with dye and cobalt light, identifying any staining pattern _____

A: Assessment:

If a foreign body is identified on the conjunctival membrane, assess "foreign body on the eye."

If exposure to liquid or powdered material is identified, assess "foreign material on the eye" and identify the material.

If the eye exam is normal with the exception of crusting or small abscess associated with an eyelash, there is no exposure history, no fever, no photophobia, and visual acuity is 20/40 or better with corrective lenses, assess "stye."

If the conjunctiva is red without exposure history as above, but all function is preserved and normal (including visual acuity 20/40 or better with corrective lenses) and there is no fever, assess "red eye of undetermined significance."

If the conjunctiva is red in a diffuse pattern but without concentration around the pupil, there is no exposure history, morning eyelid matting is reported, photophobia is present, and the cornea is not clear with staining, and there is a rash on the face or around the affected eye assess "conjunctivitis- possible herpes."

If the conjunctiva is red in a diffuse pattern but without concentration around the pupil, there is no exposure history, morning eyelid matting is reported, photophobia is present, and the cornea is clear without staining, and visual acuity is 20/40 or better corrected, assess "conjunctivitis of unknown etiology."

If the conjunctiva is red in a diffuse pattern but without concentration around the pupil, there is no exposure history, morning eyelid matting is reported, photophobia is present, and the cornea stains or has lesions visible without staining, assess "conjunctivitis with corneal involvement."

If the conjunctiva is noted to be red with the redness concentrated adjacent to the pupil (with or without pupillary changes), assess "possible anterior uveitis."

Assessment _____

Pink Eye

(This is a two page flow sheet)

CCS CORRECT CARE SOLUTIONS

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

P: Interventions:

For "foreign body on the eye,"
- Attempt to dislodge the foreign body by irrigating the eye with gently running water (warm tap water is an excellent option if "eye wash" is not easily available).
- Examine the eye repeatedly until the foreign body is gone.
- If the foreign body cannot be dislodged and removed, contact the HCP for advice.

For "foreign material on the eye,"
- Gently irrigate the eye with warm tap water for at least 15 minutes.
- Contact the HCP for advice after irrigating the eye.

For "stye"
- Instruct the patient to apply warm compresses to affected eye(s) TID-QID and to return in 2 days for nursing assessment, or sooner if symptoms worsen.
- If this is the patient's second visit for this complaint, contact HCP for advice.

For "red eye of undetermined significance"
- Reassure the patient that no serious problem has yet developed.
- Ask the patient the return the next day for nursing reevaluation, advising that any sudden changes in vision or symptoms should warrant an immediate contact to the nurse.

For "conjunctivitis- possible herpes," "conjunctivitis of unknown etiology," "conjunctivitis with corneal involvement," or "possible anterior uveitis"
- Contact the HCP for direction.

If visual acuity is more than one step different from previous testing, inform HCP.

If patient at any time complains of pain with eye movement, contact HCP immediately.

Note: Epidemic viral conjunctivitis produces punctuate staining of the cornea and is associated with preauricular lymphadenopathy and an elevated temperature. EVC is not typically a threat to vision. Herpes viral conjunctivitis produces dendritic lesions on the cornea and threatens vision. HVC requires review by a HCP with a wait of no more than overnight.

ALWAYS encourage good hand-washing practices with any patient with possible infectious conjunctivitis. Medical isolation is NOT indicated for patients with this condition.

Comments: _____

Nurse's signature and date:

_____

Reviewer's signature and date:

_____

Seizures

(This is a two page pathway)

CCS CORRECT CARE SOLUTIONS

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

Check, circle, and complete all appropriate blanks.

Date:_____ Time:_____

S: Subjective:

Patient presents seizing or staff member is called because of a prisoner seizing.
If it can be accomplished quickly (or if a second staff member can accomplish it), obtain the health record and determine if the patient has a seizure history or if the patient has any identified serious medical illnesses (Master Problem List).____

_____
_____
_____
_____

If the patient is seizing or immediately post-ictal, no history can be obtained from the patient. If the patient is alert and can provide a history, it is doubtful that the patient had a generalized seizure in the immediately preceding 30-60 minutes. If the patient is no longer seizing and others (preferably employees) witnessed the seizure, obtain information from them. _____

_____
_____
_____

If the patient is neither seizing nor post-ictal, inquire regarding previous episodes and regarding the patient's memory of this episode. _____

_____
_____

Obtain a medication history from the patient. Inquire as to any mental health issues._____

_____
_____
_____
_____

O: Examination:

T: _____ P:_____ R:_____B/P:_____
Observe and determine if the patient is currently seizing, if the patient is post-ictal, or if the patient is alert and doing well. ___

_____
_____
_____

__Wait for the seizure to terminate before trying to examine the patient.
Inspect inside the mouth for bite marks or broken teeth. Inspect to see if patient lost continence during the episode. ___

_____
_____
_____
_____

If the patient is neither seizing nor post-ictal, inquire regarding previous episodes and regarding the patient's memory of this episode. _____

_____
_____

__Observe the patient to determine if seizures are continuous, clustered, or chained. _____

_____
_____
_____
_____

If the patient has a history of diabetes, perform fingerstick glucose. _____

A: Assessment:

- If the patient has one seizure that ends in a few minutes leaving the patient confused and sleepy, assess "seizure – single."
- If seizures recur within a few minutes of ending, assess "seizure – clusters."
- If seizures continue for many minutes (more than 10 without a period of consciousness, assess "seizure – possible status epilepticus."
- If patient gives evidence that the seizure(s) is (are) not real, assess "possible pseudoseizure." Examples of such evidence include:
  - Patient is conscious during seizures – answers questions, warns observers, etc.
  - Patient actively resists being moved.
  - Patient follows people or objects with his eyes.
  - Patient moves arms and legs in a discoordinated manner rather than in tonic or clonic patterns.
  - Patient has a grand mal seizure but no post-ictal state.
- If the patient is diabetic and the blood sugar is below 50 mg/ml, utilize the hypoglycemia pathway (provide a sugar source and contact the HCP).
- If temperature is above 100, assess as "seizure with fever."

Assessment _____

Seizures

(This is a two page pathway)

Patient Name	Inmate Number	Booking Number	Date of Birth	Today's Date

P: Interventions:

If the patient is seizing, the patient from injury.
For "seizure– single,"

- Supervise the patient during the post-ictal period until the patient is fully alert.
- Review the patient's medication regimen (if any) and assure that the patient has been adherent.
- Review the record to determine when the last seizure occurred.
- If the last seizure occurred within the past week or the patient has not been adherent to the prescribed regimen, contact the HCP for advice.
- If the last seizure occurred at least a week previously and the patient has been taking medications properly, set up a chart review for the HCP on the next clinic day.

For "seizure – clusters" or "seizure – status epilepticus"
Contact the HCP for advice.

- If status epilepticus has persisted for 45 minutes, activate the emergency medical system and request an ambulance.

For "possible pseudoseizure"

- Schedule the patient to the HCP within ten days.
- If this episode is not the first and no visit has yet occurred, schedule the patient to the HCP on the next clinic day following clinic routine for next day follow-ups.

For "seizure with fever,"

- Contact HCP for direction.

Nurse's signature and date:

_____

Reviewer's signature and date:

_____

Short of Breath

CCS CORRECT CARE SOLUTIONS

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

Check, circle, and complete all appropriate blanks.
If it has been noted that patient has been putting in numerous sick calls for similar complaints, refer patient for chart review with HCP to determine appropriate plan of care and follow-up.

Date:_____ Time: _____

S: Subjective:

Patient presents short of breath.
Inquire generally regarding the patient's problems. Identify trauma, or preexisting conditions, or exposure to a toxin or allergen, blood loss, and so on. If the patient is seriously dyspneic (short of breath), pulse >120, rr>25, and oxygen saturation <91%, provide oxygen and other immediate interventions. Otherwise proceed with a more deliberate history.
Determine how long the patient has been short of breath? Is dyspnea (shortness of breath) limited to exertion, or at rest too?_____

Are there associated symptoms such as cough, chest pain, etc?_____

Does the patient have other serious medical conditions including mental health issues? _____

Does the patient take any medications? _____

O: Examination:

T: _____ P:_____ R:_____B/P:_____ Wt:_____
Inspect the chest. Are respirations labored or easy, shallow or deep, guarded or natural? Are rib spaces retracted, are nostrils flaring?_____

Does the chest move symmetrically? _____

Inspect the skin for cyanosis (bluish hue), including nail beds and region around the mouth _____

Other observations: _____

A: Assessment:

If the patient has essentially normal vital signs, and the history and examination is unremarkable, "Alteration in Mental Status: Anxiety."

If the patient has an alternative serious cause for dyspnea that has been identified, specific interventions should be provided as appropriate. If the patient appears very ill with dyspnea, assess "Impaired Gas Exchange."

If the patient has a history of asthma and is believed to be experiencing an asthma exacerbation, assess "Impaired Gas Exchange, Asthma Exacerbation" and exit this protocol. Proceed to the pathway describing asthma.

Assessment_____

P: Interventions:

For "Alteration in Mental Status: Anxiety," reassure the patient and terminate this pathway, and consider referring to the pathway on anxiety.

For "Impaired Gas Exchange" provide general interventions (oxygen by mask at 10 lpm, IV line at KVO rate) and obtain direction from a higher level HCP). If a serious cause can be identified, specific interventions should be provided.

For "Impaired Gas Exchange, Asthma Exacerbation" exit this pathway, and proceed to the pathway describing asthma exacerbations.

Comments: _____

Nurse's signature and date:

Reviewer's signature and date:

Sinus Complaints

Patient Name	Inmate Number	Booking Number	Date of Birth	Today's Date

Check, circle, and complete all appropriate blanks.

If it has been noted that patient has been putting in numerous sick calls for similar complaints, refer patient for chart review with HCP to determine appropriate plan of care and follow-up.

Date:_____ Time:_____

S: Subjective:
Describe the symptoms, including onset, duration, severity, and so on. _____

Inquire regarding seasonal recurrence. _____

Inquire regarding cough, weight loss, and night sweats. _____

If patient has asthma or COPD inquire if the condition is causing any problems. _____

Obtain smoking history. _____

O: Examination:
T:_____ P:_____ R:_____
Inspect the oral cavity and the nares. _____

Inspect the face to identify erythema (redness) over the major sinus cavities. _____

Palpate the face over the sinus cavities and determine if pain is elicited. _____

Observe whether the patient can breathe through his nose.

Palpate the neck and mastoid areas for tenderness or swollen lymph nodes. _____

A: Assessment:
Identify inciting factor if possible. _____

Assess as "sinusitis" and preface by inciting factor if identified (allergic, seasonal, etc). _____

If a complication is identified, append the complication to the diagnosis (infection, severe pain, etc). _____

Assessment _____

P: Interventions:

For "Sinusitis" without complication:

- Advise the patient regarding the diagnosis and that the condition is not a serious medical condition.
- Inform the patient that treatment is not required and that patient may take comfort measures on his own. Simple comfort measures (depending upon facility options) might include increased showers, application of a warm wet towel, etc).
- Advise the patient to return if infection worsens or severe pain develops.

For "Sinusitis" with identified complication:

- If patient has fever over 100.9 or severe pain, contact HCP for direction.
- If patient has asthma or COPD exacerbated by sinusitis but there is no current exacerbation, refer patient to HCP within one week. (If there is current exacerbation, contact HCP for direction.)
- If there another non-urgent complication, refer patient to HCP within one week.

Comments: _____

Nurse's signature and date:

_____

Reviewer's signature and date:

_____

Substance Abuse Withdrawal

(This is a two page flow sheet)

CCS CORRECT CARE SOLUTIONS

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

Check, circle, and complete all appropriate blanks.

Date: _____ Time: _____

S: Subjective:

Identify what substances the patient uses, including the frequency, quantity, routes of administration, and last usage. _

Inquire regarding previous withdrawal experiences (previous withdrawal experiences often provide useful information regarding what to expect this time). _____

Identify what symptoms the patient is now experiencing, if any.

Inquire regarding other serious medical conditions that may make the inmate high risk for withdrawal. _____

Inquire regarding pregnancy. _____

O: Examination:

T_□___P___□_BP_____RR_____

Determine the level of consciousness and orientation. _____

For alcohol users, perform the CIWA-Ar. The frequency for re-determination of vital signs and CIWA-Ar varies according to the findings; the more abnormal, the more frequent. _____

Assess gait. _____

Assess skin. _____

Inspect for tremor. _____

Based upon history, inspect and assess other organ systems. _

Make a gross determination of nutritional status. _____

Inspect pupils. _____

A: Assessment:

Assess dependency and/or withdrawal as appropriate, naming the substance.
If withdrawal is occurring, identify it.
Assessment _____

P: Interventions:

Use of prescription medication other than for emergency treatment requires contact with the HCP.
The following guidelines are provided to assist the nurse in understanding what to expect and how to monitor the patient.

For inmates with histories suggestive of alcohol withdrawal:

- If the CIWA-Ar is 10 or less, and vital signs are normal, no specific therapy is required. Vital signs and CIWA-AR should be repeated again in 4-8 hours.
- If the test is again 10 or less, repeat it again in 12-18 hours. If the CIWA-Ar remains 10 or less for 24 hours, no specific intervention is necessary and this pathway terminates. If the CIWA-Ar does not remain at this low level, AWS is moderate or severe and this pathway proceeds.
- Provide thiamine 100mg PO QDay x 30 days and folate 1mg PO QDay x 30 days unless any are otherwise contraindicated. If patient is not capable of taking oral medication, call HCP for orders; anticipate thiamine 100mg IM for 5 days or longer.
- If CIWA-Ar is above 10, contact the HCP for direction. Anticipate use of oral/injectable lorazepam or oral librium.
- Reassess the patient as directed by the HCP but no less often than every six hours until the risk for severe alcohol withdrawal is passed. For a time assessment may be requested hourly.
- Continue to reassess vital signs and CIWA-Ar until it is below 10 for 24 hours.
- Contact the HCP if CIWA-Ar is repeatedly above 15.
- If CIWA-AR is above 20, ask HCP if the jail can continue to manage the patient.
- Contact the HCP if blood pressure goes above 200 systolic or 120 diastolic, or into the range of shock.
- Contact the HCP if pulse goes above 140 for more than a

Substance Abuse Withdrawal

(This is a two page flow sheet)

CCS CORRECT CARE SOLUTIONS

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

few minutes.
- Contact the HCP if seizures recur for more than a few minutes.
- Contact the HCP if patient becomes fully hallucinated or delirious.
- Contact the HCP if other dangerous signs are noted.

For inmates with histories suggestive of benzodiazepine withdrawal:
- Contact HCP and anticipate orders to provide a long acting oral benzodiazepine. May use stock meds.
- Reassess patient every six hours for at least 24 hours or until risk of uncontrolled withdrawal is passed (exact duration to be determined by HCP on-call).
- Contact the HCP if blood pressure goes above 200 systolic or 120 diastolic, or into the range of shock.
- Contact the HCP if pulse goes above 140 for more than a few minutes.
- Contact the HCP if seizures recur for more than a few minutes.
- Contact the HCP if patient becomes fully hallucinated or delirious.
- Contact the HCP if other dangerous signs are noted.

For barbiturates
- Contact HCP and anticipate directions to provide oral or injected phenobarbital.
- Reassess patient every six hours for at least 24 hours or until risk of uncontrolled withdrawal is passed (exact duration to be determined by HCP on-call).
- Contact the HCP if blood pressure goes above 200 systolic or 120 diastolic, or into the range of shock.
- Contact the HCP if pulse goes above 140 for more than a few minutes.
- Contact the HCP if seizures recur for more than a few minutes.
- Contact the HCP if patient becomes fully hallucinated or delirious.
- Contact the HCP if other dangerous signs are noted.

For opiates
- Rule out pregnancy by history, physical examination, or urine test. If pregnancy is present, contact HCP for direction.
- Assure the patient that withdrawal will pass and that we will provide medications to blunt symptoms. Make sure the patient understands that withdrawal symptoms cannot be eliminated.
- Contact the HCP and anticipate orders for clonidine 0.1 or 0.2 mg PO up to QID (do not administer if blood pressure is less than 90/60).
- Reassess patient every six hours for at least 24 hours or until risk of uncontrolled withdrawal is passed (exact duration to be determined by HCP on-call).
- Offer clear liquid diet during active withdrawal.
- If diarrhea is present, offer loperamide (Imodium) 4 mg PO (additional 2 mg doses with additional loose bowel movements to a maximum of 16 mg during any 24 hour period).
- If muscle cramps are disabling, contact HCP and request orders for muscle relaxer.
- If abdominal cramps are disabling, contact HCP and request orders for dicyclomine (Bentyl) 20 mg PO TID.
- Offer acetaminophen 650 mg PO for pain, up to four times in any 24 hour period. If patient has a documented allergy to acetaminophen, then offer ibuprofen 200mg PO TID x 24 hours (unless otherwise contraindicated).
- If vomiting develops, offer meclizine 25mg PO TID x 24 hours. If unable to tolerate PO or if vomiting not controlled after meclizine, contact HCP on-call.
- Contact the HCP if seizures, delirium, or hallucinosis develop.
- Contact the HCP if other dangerous sign is noted.

For patients with withdrawal from more than one substance, contact HCP on-call for orders.

Nurse's signature and date

_____

Reviewer's signature and date

_____

Upper Respiratory Infection

Patient Name	Inmate Number	Booking Number	Date of Birth	Today's Date

Check, circle, and complete all appropriate blanks.
If it has been noted that patient has been putting in numerous sick calls for similar complaints, refer patient for chart review with HCP to determine appropriate plan of care and follow-up.

Date:_____ Time:_____

S: Subjective:

Describe the symptoms, including onset, duration, severity, and so on_____

Inquire regarding cough, weight loss, and night sweats, hemopytsis (coughing up blood)_____

Identify complicating diagnoses if any_____

Inquire regarding patient's concerns_____

Obtain smoking history_____

O: Examination:

T: _____ P:_____ R:_____B/P:_____ Wt:_____
Inspect the oral cavity, the nares, the oral pharynx, and the ear canals_____

Palpate the neck and mastoid areas for tenderness or swollen lymph nodes _____

Listen to the lungs for wheezes or rales. _____

A: Assessment:

If the symptoms are less than one week old and findings are normal or limited to mild inflammation of the throat and nares, low-grade swelling of the lymph nodes, low-grade fever (less than 101 F), and nasal discharge, assess as "Upper Respiratory Infection, Uncomplicated"

Complicating signs or symptoms such as persistence for more than 7 days, significantly abnormal vital signs, temperature above 101 F, extreme inflammation or tenderness, or abnormal pulmonary findings require an assessment of "Upper Respiratory Infection – complicated."

Assessment _____

P: Interventions:

For "URI - Uncomplicated"

- Advise the patient regarding the diagnosis.
- Inform the patient that it will resolve without treatment and that high humidity (application of warm wet towel, hot shower, etc) will increase comfort
- A warm water gargle (tap water or salted water) can decrease sore throat discomfort
- Advise the patient to return if symptoms worsen or persist longer than 7 days.

For "URI - Complicated"

- If the patient reports weight loss, cough (especially productive cough or hemoptysis), and night sweats, place a mask on the patient and contact the HCP immediately. (This patient may have infectious tuberculosis.)
- If severe wheezing or rales are identified, contact the HCP immediately.

Comments: _____

Nurse's signature and date:

_____

Reviewer's signature and date:

_____

Urinary Tract Symptoms

Patient Name	Inmate Number	Booking Number	Date of Birth	Today's Date

Check, circle, and complete all appropriate blanks.
If it has been noted that patient has been putting in numerous sick calls for similar complaints, refer patient for chart review with HCP to determine appropriate plan of care and follow-up.

Date: _____ Time: _____

S: Subjective:

For pain inquire regarding onset and duration, location, severity, characteristics, what relieves it, and what exacerbates it. _____

For visible bloody urine inquire regarding onset and duration, quantity, and whether the bleeding is pure blood, mixed with urine, or mixed with clots. _____

For hesitancy, urgency, dribbling, and nocturia (increased frequency of nighttime urination), inquire regarding speed of onset and severity. _____

For urinary discharge inquire regarding onset, quantity, color and thickness, and when it is noted. _____

For increased frequency inquire regarding previous diagnosis of diabetes, onset and severity, hunger and weight changes.__

O: Examination:

T: _____ P:_____ R:_____B/P:_____ Wt:_____
Examine discharge, bloody urine, or whatever is available. ___

Apply fist percussion to both costovertebral angles to search for acute kidney tenderness. _____

Obtain dipstick urinalysis to identify microscopic hematuria, glucose, or presence of infection._____

A: Assessment:

Assess "alteration in urinary function" and clarify it with additional information as appropriate (urethritis, cystitis, pyelonephritis)
If problem is accompanied by severe cramping pain, assess "alteration in urinary function – rule out stone."
If increased urinary frequency is present together with glucose in the urine, assess as "rule out diabetes mellitus." If there are other urinary tract symptoms, this assessment will be in addition to a urinary tract assessment.
Assessment _____

P: Interventions:

If the patient has new onset diabetes mellitus, possible stone, or pyelonephritis, infection demonstrated by dipstick, gross hematuria, or a fever above 101, contact the HCP for advice.

For other assessments, schedule patient to see the HCP on a routine basis.

Comments: _____

Nurse's signature and date:

_____

Reviewer's signature and date:

_____

Vaginal Discharge

(this is a two page flow sheet)

CCS CORRECT CARE SOLUTIONS

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

Check, circle, and complete all appropriate blanks.
If it has been noted that patient has been putting in numerous sick calls for similar complaints, refer patient for chart review with HCP to determine appropriate plan of care and follow-up.

Date:_____ Time:_____

S: Subjective:

Inquire regarding the presence of symptoms suggestive of a urinary tract infection (pain or burning with urination, dark or bloody urine, pain at one or both costovertebral angles, fever). _____

Inquire regarding the nature of the discharge. _____

Inquire regarding previous similar symptoms and treatment previously received _____

Inquire regarding any previous history or current symptoms of PID (fever, lower pelvic pain, pain upon standing upright, treatment for pelvic pain). _____

Inquire regarding pregnancy. _____

O: Examination:

T: _____
Inspect the introitus (vaginal opening) noting any abnormalities _____

Inspect the vaginal vault for any pooled fluids. _____

If urinary symptoms are present, obtain a clean catch urine sample for dipstick analysis and perform it. _____

If urinary symptoms are present, perform gentle fist percussion of both costovertebral angles. _____

A: Assessment:

If there is no discharge noted, no signs or symptoms of a urinary tract infection or PID, and no abnormalities noted, assess as "alteration in comfort – no problem identified."

If there is no discharge or abnormality noted other than signs or symptoms of a urinary tract infection, exit this pathway and use urinary tract symptom pathway.

If patient is not pregnant, does not have a temperature above 99.9, and does not have signs or symptoms of a urinary tract infection or PID but does have a thick or curdy white discharge with little or no odor and does have whitish areas on the vaginal vault, assess as "alteration in comfort – vaginal candidiasis."

If patient is not pregnant, does not have a temperature above 99.9, and does not have signs or symptoms of a urinary tract infection or PID but does have a vaginal discharge other than thick and white, assess as "alteration in comfort- vaginal discharge, non-candidal".

If patient has a vaginal discharge and is pregnant, or has a temperature above 99.9, or does have signs or symptoms of PID assess as "alteration in comfort – vaginal discharge, complicated"

If CVA percussion reveals tender kidneys, assess "alteration in urinary tract function – possible pyelonephritis."

Assessment _____

Vaginal Discharge

(this is a two page flow sheet)

CCS CORRECT CARE SOLUTIONS

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

P: Interventions:

For "alteration in comfort – no problem identified"

- Reassure patient.
- If this is the second time within 10 days for this presentation, refer to HCP for routine evaluation.

For "alteration in comfort – vaginal candidiasis"

- Inquire regarding allergies to clotrimazole
- If not allergic and not pregnant, provide clotrimazole
- If allergic or pregnant, refer to HCP for chart review to determine appropriate treatment and follow-up.
- Instruct patient regarding genital hygiene
- If patient has been treated with clotrimazole within the past 2 weeks and the problem persists, refer to HCP on a routine basis.

For "alteration in comfort- vaginal discharge, non-candidal"

- Refer patient for chart review with HCP to determine appropriate treatment and follow-up.

For "alteration in comfort – vaginal discharge, complicated-possible PID"

- call HCP for direction

For "alteration in urinary tract function – possible pyelonephritis"

- contact HCP for direction.

Comments: _____

_____

_____

_____

_____

_____

_____

Nurse's signature and date:

_____

Reviewer's signature and date:

_____

Vision Problems

CCS CORRECT CARE SOLUTIONS

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

Check, circle, and complete all appropriate blanks.
If it has been noted that patient has been putting in numerous sick calls for similar complaints, refer patient for chart review with HCP to determine appropriate plan of care and follow-up.

Date:_____ Time: _____

S: Subjective:

Patient complains of blurred distant vision or difficulty reading small print.
Ask the patient what types of problems he is having _____
_____
_____
_____
Ask if the problem is new and if it developed suddenly. _____
_____
_____
Inquire about recent eye trauma. _____
_____
_____
Inquire regarding the presence of other visual problems; ask specifically about the presence of pain. _____
_____
_____
Review current medication usage. _____
_____
_____
_____
Patient complains that he needs support for contact lenses.
Ask the patient if he has contact lenses and how old the lenses are. _____
_____
Ask the patient if he has any eye conditions. _____
_____
Patient complains that he has broken his glasses.
Ask the patient when and where he got the glasses, and how they broke._____
_____
_____

O: Examination:

Perform a Snellen examination, with corrective lenses if the patient has them. Include combined visual acuity. Note as part of the results whether the patient was wearing corrective lenses. Please indicate the degree of difficulty that the patient appeared to have during this exam. If unable to do Snellen, have patient count fingers from 12 and 6 feet away; if unable to do this, determine if patient can visualize light shined in eye(s).

_____
_____
_____
_____
If near vision is a problem, ask the patient to read standard-sized text._____
_____
_____

If the patient is requesting support for contact lenses, obtain combined visual acuity both with and without correction._____
_____
_____
_____

If glasses now broken were provided while in the correctional facility, determine the date they were provided. _____
_____
_____
_____

A: Assessment:

Assess as "alteration in visual acuity" and describe the concern.
Assessment _____

P: Interventions:

- If combined visual acuity is 20/100 or better, distant vision correction is not necessary unless there is a special circumstance. If combined visual acuity is worse than 20/100 or a special circumstance is identified, refer the health record to the HCP for review.
- If the patient can not read standard-sized text, refer health record to HCP for review.
- If the change in visual acuity was sudden or very rapid, call HCP for direction.

For patient requesting contact lens support

- If patient does not qualify for glasses without wearing lenses, no support should be provided.
- If patient qualifies for glasses, has usable contact lenses, and security considerations permit, order solutions for support (available from the pharmacy). If security does not permit or lenses are not usable, either obtain glasses from the family or refer record to HCP for review.

For broken glasses

- If patient's glasses are broken and were provided by the jail, but patient does not qualify for glasses, glasses will not be provided.
- If patient's glasses are broken and family can provide glasses from the outside, encourage family to do so.
- If the patient needs glasses and the family cannot bring in acceptable glasses, we should provide them unless the glasses were less than two years old, in which case the patient may be required to pay associated replacement costs. Refer to HCP for chart review.

Nurse's signature and date:

_____

Reviewer's signature and date:

_____